Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West District
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Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: May 31, 2023	
Inspection Number: 2023-1203-0004	
Inspection Type: Follow up Critical Incident System	
Licensee: Golden Dawn Senior Citizen Home	
Long Term Care Home and City: Golden Dawn Nursing Home, Lions Head	
Lead Inspector Daniela Lupu (758)	**Inspector Digital Signature** Jessica F Bertrand Digitally signed by Jessica F Bertrand Date: 2023.06.02 08:39:36 -04'00'

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 9-12, and 15-19, 2023

The following intake(s) were inspected:
- Intake #00004667, related to missing resident
- Intake #00021330, related to falls prevention and management
- Intake: #00086558, Follow up to the Order of the Director from original inspection #2022_1203_0002, related to prevention of abuse and neglect policy, with a compliance due date of August 5, 2022.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:
Order of the Director from Inspection #2022-1203-0003 related to FLTCA, 2021, s. 104 (4) inspected by Daniela Lupu (758)

The following **Inspection Protocols** were used during this inspection:

Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect

Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (10) (b)

The licensee failed to ensure that a resident was reassessed and plan of care related to falls prevention was reviewed and revised when their care needs changed, and the care set out in their plan was no longer necessary.

A resident was identified as a high risk for falls. The resident had a fall and had a significant change in status. The resident's plan of care documented that a specified falls prevention intervention was to be in place at all times.

Observations on two dates during the inspection showed that the resident did not have the intervention in place.

A registered staff member said the resident no longer needed the intervention in place as the resident's condition improved.

The registered staff member and the Director of Care (DOC) said the resident's care plan should have been updated to reflect the resident's current needs.

Sources: observations of a resident's falls prevention interventions, a resident's care plan, progress notes and interviews with a registered staff member, the DOC and other staff. [758]

Date Remedy Implemented: May 17, 2023

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee failed to ensure that the care set out in a resident's plan of care related to falls prevention was provided to the resident as specified in the plan.

Rationale and Summary

A resident was identified to be at high risk for falls.

The resident's plan of care documented that interventions were to be in place for falls prevention.

Observations on three dates during the inspection showed that the resident did not have in place the required interventions.

The DOC and the home's Resident Assessment Instrument (RAI) Coordinator/Resource Manager said that all interventions should have been in place as specified in the resident's plan of care.

By not ensuring that interventions were in place as specified in the resident's plan of care, increased the resident's risk for falls.

Sources: observations of a resident's falls prevention interventions, a resident's care plan, physician's orders, risk management reports, and interviews with the DOC, RAI Coordinator/Resource Manager and other staff. [758]

WRITTEN NOTIFICATION: Directives by Minister

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that the home carried out the policy directive related to conducting regular Infection Prevention and Control (IPAC) audits.

In accordance with the Minister's Directive, COVID-19 Response Measures for Long-Term Care Homes, effective August 30, 2022, issued under the Fixing Long-Term Care Act, 2021, the licensee was required to ensure that requirements for conducting regular IPAC audits were followed as set out in the Ministry of Health COVID-19 Guidance Document for Long-Term Care Homes in Ontario, effective March 31, 2023.

Rationale and Summary

The Ministry of Health COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units, effective March 31, 2023, section four, documented homes must complete IPAC audits every two weeks unless in outbreak.

A review of the home's COVID-19 Self-Assessment Audit Tools for LTCHs showed that no self-assessment audits were completed over a six-week period.

The home's Interim IPAC Lead said the self-assessment audits should have been completed every two weeks as the home was not in an outbreak during the six-week period.

By not completing the COVID-19 self-assessments audits at the frequency required, there was a risk that IPAC related issues could not be identified and addressed in a timely manner.

Sources: Minister's Directive, COVID-19 Response Measures for Long-Term Care Homes, effective (August 30, 2022), COVID-19 Guidance Document for Long-Term Care Homes (LTCHs) in Ontario, (March 31, 2023), the home's outbreak of communicable disease plan, the home's COVID-19 Self-Assessment audits, and an interview with the Interim-IPAC Lead. [758]

WRITTEN NOTIFICATION: Bed Rails

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 18 (1) (a)

The licensee has failed to ensure that where bed rails were used, a resident was assessed, and their bed system was evaluated to minimize the risk of harm to the resident.

Rationale and Summary

Upon admission to the home, a resident used bed rails.

The home's policy, titled Bed Rails, documented nurses and physiotherapist (PT) or occupational therapist (OT) were to complete in collaboration the electronic Bed Rail Assessment in Point Click Care (PCC). On a quarterly basis and with a significant change in resident condition, the resident was to be reassessed for continued use of bed rails.

A resident had a significant change in their condition and additional bed rails were added to the resident's bed system.

No bed rail assessment was completed quarterly or when the resident had a significant change in their condition and additional bed rails were added.

The home's RAI Coordinator/Resource Manager and the DOC said the resident's assessments were not completed as required when bed rails were used.

Staff not assessing the resident for the use of bed rails when the resident's condition changed increased the risk of harm to the resident.

Sources: a resident's care plan, bed rail assessments, progress notes, documentation survey reports, home's Bed Rails policy, and interviews with the RAI Coordinator/Resource Manager, DOC, and other staff. [758]

WRITTEN NOTIFICATION: Bed Rails

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 18 (1) (b)

The licensee has failed to ensure that when a resident used bed rails, all potential zones of entrapment were taken into consideration.

Rationale and Summary

A resident's plan of care documented that bed rails were to be in place.

The home's policy, titled Bed Entrapment Prevention, documented that the Environmental Services Manager or designate would assess the bed system using the Bed Entrapment kit when there was a change in the components of the bed system, such as rails or mattress. One zone should be tested even when the bed rails were not in use.

Additionally, the attachment of the above policy, titled Bed entrapment safety tips, documented seven bed entrapment zones.

The Bed System Measurement Device Test Results Worksheet, completed for a resident's bed, did not include testing for the risk of entrapment for all zones.

The home's RAI Coordinator/Resource Manager said the home did not complete a full assessment of the resident's bed system including all potential zones of entrapment.

By not assessing all potential bed entrapment zones there was potential risk to the resident.

Sources: a resident's care plan, the home's Bed Entrapment policy, Bed Entrapment Safety Tips policy, a resident's Bed System Measurement Device Test Results Worksheet, and interviews with the DOC and RAI Coordinator/Resource Manager and other staff. [758]

WRITTEN NOTIFICATION: Windows

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 19

The licensee has failed to ensure that a resident's window that opened to the outdoors and was accessible to the resident could not be opened more than 15 centimeters (cm).

Rationale and Summary

A critical incident report was received by the Ministry of Long Term Care (MLTC) related to an incident involving a resident.

A registered staff member found a resident bedroom window was wide open with the window screen removed, and an incident had occurred involving a resident.

The home's former DOC and the maintenance personnel said the resident's window was not properly installed and the mechanism that prevented the window from opening more than 15 cm was faulty.

The former DOC and the former Administrator said that a preventative maintenance schedule to check window safety mechanisms was not in place, as required.

By not ensuring that a resident's window could not be opened more than 15 cm, there was a risk to the resident's safety.

Sources: A CI report, a resident's progress notes, the home's investigation notes, and interviews with the Former DOC, the former Administrator, the maintenance personnel, and a registered staff member. [758]

WRITTEN NOTIFICATION: General Requirements for Programs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)

The licensee failed to ensure that a resident's falls prevention interventions were documented.

Rationale and Summary

A resident was identified at high risk for falls.

Following a fall and significant change in condition, falls interventions were implemented for the resident.

These interventions were not documented in the resident's plan of care until a month later. The resident continued to fall during this time.

By not documenting the falls prevention interventions in the resident's plan of care, there was potential for staff not to consistently ensure these interventions were in place.

Sources: a resident's care plan, risk management reports, progress notes and interviews with the DOC and other staff. [758]

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 1.

The licensee has failed to ensure that the Director was informed no later than one business day of an incident in which a resident was missing from the home for less than three hours and returned to the

home with no injury or adverse change in their condition.

Rationale and Summary

A resident was missing from the home and was located within a specified time-period.

The incident was not reported to the Director until five days later.

The home's failure to report to the Director within one business day the incident where a resident was missing from the home less than three hours may have delayed the Director's ability to respond to the incident in a timely manner.

Sources: A CI report, and interviews with the former DOC and former Care Manager. [758]

WRITTEN NOTIFICATION: Conditions of licence - Licensee must comply

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)

The licensee has failed to comply with the Order of the Director issued on July 27, 2022, related to FLTCA, 2021, s.25 (2)(e), with a compliance due date of August 5, 2022, associated with original inspection #2022_1203_0002.

The home's Prevention of Abuse and Neglect policy was not revised as required.

Rationale and Summary

The home's Prevention of Abuse and Neglect policy did not include procedures for investigating and, in particular, responding to alleged, suspected, or witnessed abuse of a resident, except for the procedure for responding to a specified type of abuse of a resident.

Additionally, the policy did not include information as to what would constitute the specified type of abuse or directions to be followed for investigating this type of incident.

The DOC said that not all the steps outlined in the procedure for responding to specified type of abuse would be applicable when responding to other incidents of abuse of a resident. They also said the policy did not direct staff as to the procedure for investigating alleged, suspected, or witnessed specified type of abuse of a resident.

The home's prevention of abuse and neglect policy was not revised as specified by the Director's Order, therefore staff could not receive training on the revised policy, specifically related to investigating and responding to alleged, suspected and witnessed specified type of abuse of residents.

Sources: Order of the Director issued on July 27, 2022, the home's prevention of abuse and neglect policy, the home's staff training records and interviews with the DOC, and registered staff. [758]

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Written Notification NC #009

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $2200.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

Compliance History:
-Written Notification from inspection #2022-1203-0003, related to FLTCA, 2021, s. 104 (4) , issued on November 16, 2022.
-Order of the Director from inspection #2022_1203_0002, related to FLTCA, 2021, s. 25 (2) (e), issued on July 27, 2022, CDD August 5, 2022.

This is the second time the licensee has failed to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice. Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

NOTICE OF RE-INSPECTION FEE

Pursuant to section 348 of O. Reg. 246/22 of the Fixing Long-Term Care Act, 2021, the licensee is subject to a re-inspection fee of $500.00 to be paid within 30 days from the date of the invoice.
A re-inspection fee applies since this is, at minimum, the second follow-up inspection to determine compliance with the following Compliance Order(s) under s. 155 of the FLTCA, 2021:

-Order of the Director from inspection #2022_1203_0002, related to FLTCA, 2021, s. 25 (2) (e), issued on July 27, 2022, CDD August 5, 2022.

-The first follow up inspection was conducted in inspection #2022-1203-0003 (intake #00086558), a Written Notification was issued related to FLTCA, 2021, s. 104 (4), issued on November 16, 2022.

Licensees must not pay a Re-Inspection Fee from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the Re-Inspection Fee.

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.